POINT OF CONTACT/STATEMENT OF INTENT

(For DHS Use Only)

_____, provider intends to apply for direct care worker payment.

_____, provider will follow the guidance and pass through appropriate monies received for the direct care workers payments.

_____
Signature of Agent

Date: _____

Point of contact [Name]: _____

Phone: _____

Email: _____

Is the point of contact the same for all sites of service? Yes / No

If no, provide additional information by site name, contact name, phone, and email below.

Upon completion of all sections above, please submit this report to the attention of DCWP by email, to: DCWP@dhs.arkansas.gov, along with your Provider Reporting